DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155523	B. WING			R-C 09/29/2011	
NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W STATE RD 46 ELLETTSVILLE, IN 47429			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 000	000 INITIAL COMMENTS		F	000			
	Paper compliance for complaint IN0009498 August 23, 2011.	or the investigation of 81 completed on					
	Review Date: September 29, 2011						
	Facility Number: 000 Provider Number: 15 AIM Number: 10026	55523					
	Surveyor: Deborah M. Beers, R.N.						
	found to be in compli	om Health Care Center was ance with 42 CFR Part 483, AC 16.2, in regard to the view to the complaint					
ADODATODY		SUPPLIER REPRESENTATIVE'S SIGNATUF			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.